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| V 000 | INITIAL COMMENTS<br><br>This Statement of Deficiencies was generated as the result of an initial Medicare certification survey (Health and Life Safety Code) conducted at your facility on 2/17/09 through 2/18/09.<br><br>The census was four.<br>Four clinical records were reviewed.<br>Four patients were interviewed.<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.<br><br>The following regulatory deficiencies were identified: | V 000 | | |
| V 111 | 494.30 INFECTION CONTROL<br><br>The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to follow up on a positive skin test for tuberculosis for 1 of 4 patients (#4) and failed to provide the correct tuberculin skin testing procedure for 2 of 4 patients. (#2 and #3)<br><br>Findings include:<br><br>Patient #4 was admitted to the facility on 1/10/09. He transferred from a sister unit where he had dialyzed for approximately five years. His end | V 111 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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stage renal disease (ESRD) was due to diabetes Type 2. His primary language was Spanish.

On 5/20/08, while still at the previous clinic, Patient #4 was given a tuberculosis skin test. When the test was read on 5/22/08, the results were 18 mm, which according to the legend, was a significant positive result. Review of the patient record did not reveal any follow up for the positive result while at the previous facility. The tuberculosis skin test report was then transferred to Patient #4's new record at the current facility. The patient record did not disclose that any concern was noted or that any follow up for the positive tuberculosis test was pursued.

An interview was conducted with the Unit Charge Nurse on 2/18/09. She was unsure of what had transpired with the positive test. After some research and conversing with Patient #4, she disclosed that at the time of the positive reading, she had told the patient that he needed to get a chest x-ray to rule out an active disease. Patient #4 acknowledged that he had never obtained the requested chest x-ray. The Unit Charge Nurse confirmed that no follow up had been done after the request for the chest x-ray was made to the patient.

Further investigation confirmed that Patient #4 had never had a previous skin test or chest x-ray for tuberculosis since beginning dialysis in 2005.

Patient #2 and Patient #3 transferred from another dialysis clinic. Patient #2 was admitted to the clinic on 1/9/09. Patient #3 was admitted to the clinic on 1/14/09.

Both patients had been on dialysis for longer than

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| V 111 | Continued From page 2<br>two years when they were transferred. Review of both clinical records revealed single step tuberculosis testing was performed in 2008.<br><br>The Registered Nurse Clinic Manager was asked to provide evidence that the clinic had received either a documented history of two sequential years of tuberculosis testing (2007 and 2008) from the previous clinic for both Patient #2 and Patient #3 or evidence of a two-step test when they were admitted to the current clinic. The Registered Nurse Clinic Manager could not provide any evidence of two sequential year tuberculosis testing from the other clinic. She confirmed the other clinic could not provide this information. She also confirmed Patient #2 and Patient #3 did not receive a two-step test upon their admission to the current clinic. | V 111 | | |
| V 455 | 494.70(a)(4) PATIENTS' RIGHTS<br><br>[The patient has the right to-]<br>(4) Privacy and confidentiality in personal medical records;<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure that patient medical information was kept confidential in 3 of 3 observations.<br><br>Findings include:<br><br>The initial entrance occurred at approximately 8:30 AM on 2/17/09. The only staff member present was the Bio-med technician who was conducting a safety inspection. The office manager had left the office to go to another clinic to perform clerical errands. The Bio-med | V 455 | | |

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technician confirmed he probably would have left before the office manager's return if the surveyors had not arrived. The Bio-med technician confirmed he did not know when the office manager's estimated return was. He confirmed he would secure the building, but not the individual offices when he left.

An initial tour of the facility revealed that the clinical records of the four active patients and one discharged patient were located in a closet next to the fax/copy machine. This closet contained office supplies, local phone books and other clerical supplies.

The office manager was interviewed at approximately 10:00 AM on 2/17/09. She confirmed she had left the closet unlocked when she left the building.

During a patient observation on 2/18/09, the office manager used the intercom to inform the registered nurse that a lab result had been received. The office manager said the patient's full name and what lab test had been performed. The intercom message could be heard in the general patient care area. There was still one patient receiving treatment in the unit.

Cross reference V 727 - Protection of the Patient's Record
During observation of the initial start up on 2/18/09, a total of four patients were being placed on the dialysis machines. It was noted that each patient had a flow sheet for that dialysis treatment on a clip board on top of their respective machines. The flow sheet contained medical data such as their frequency for dialysis, the length of treatment time, medications received

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| V 455 | Continued From page 4<br>and type of dialysis access. This information was accessible to anyone standing near the dialysis machines. In an interview with the Charge Nurse and a patient care technician 2/18/09, they disclosed that they were not aware that there was a need for privacy and confidentiality of the patient's medical records or that the flow sheets should be covered in some manner. | V 455 | | |
| V 470 | 494.70(c) POSTING OF RIGHTS<br><br>The dialysis facility must prominently display a copy of the patient's rights in the facility, including the current State agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure that a copy of the patient's rights were prominently displayed in the facility where it could be easily seen and read by patients during 2 of 2 days of the survey.<br><br>Findings include:<br><br>Observations of the main lobby area on 2/17/09 and 2/18/09 revealed a large bulletin board, approximately four by six feet in size, positioned on the wall. A letter-sized form was located at counter level on the far right of the sliding glass window of the office/reception area. This form included information of the facility Grievance Policy, which included the State agency and End Stage Renal Dialysis Network contact addresses and complaint phone numbers. This information could only be read when a patient was at the window and required bending over to read it. | V 470 | | |

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| V 470 | Continued From page 5<br><br>There was no other information posted regarding the patient's rights in the facility.<br><br>An interview with the Registered Nurse Clinical Manager at 12:00 PM on 2/18/09, confirmed that the bulletin board was where the patient's rights information was to be posted and it was the responsibility of the social worker to post the rights. A phone contact with the social worker by the Registered Nurse Clinical Manager revealed the social worker thought that having the individual patient sign a copy and place it in their clinical record met the requirement. | V 470 | | |
| V 506 | 494.80(a)(3) ASSESSMENT CRITERIA<br><br>[The patient's comprehensive assessment must include, but is not limited to, the following:] Immunization history, and medication history.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to administer the Pneumovax vaccine to 2 of 4 patients who had expressed a desire to receive the vaccine. (#3 and #4)<br><br>Findings include:<br><br>Patient #4 was admitted to the facility on 1/10/09. He transferred from a sister unit where he had dialyzed for approximately five years. His end stage renal disease (ESRD) was due to diabetes Type 2. His primary language was Spanish.<br><br>Review of the patient record revealed a form with the heading "DCI Nevada Clinics." Under | V 506 | | |

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Pneumonia Vaccine was the handwritten statement, dated 12/12/08, "would like to receive pneumovax." Further review of the record failed to reveal evidence that Patient #4 had ever received the vaccine.

In an interview with the Charge Nurse on 2/18/09 at approximately 8:45 AM, she indicated that Patient #4 had not yet received the vaccine and that when he was asked about wanting to receive the vaccine, Patient #4 was still at the old clinic. The old clinic was asking all patients so that the clinic would know how much vaccine to order. Patient #4 then moved to this clinic. The Charge Nurse stated that she had not had the opportunity to get the written material about the vaccine to the patient and that the new clinic needed to order their own Pneumovax vaccine. The Charge Nurse was not sure if the vaccine was available at the time of the interview.

Observation of the medication refrigerator revealed an unopened vial of Pneumovax vaccine. The receptionist provided the invoice for the delivery of the vaccine. The invoice showed that the vaccine was received by the clinic on 1/27/09. Patient #4 had not received the Pneumovax vaccine at the conclusion of the survey.

Patient #3 was transferred from another dialysis clinic on 1/14/09. The patient required in-clinic hemodialysis treatments after an acute care hospitalization for endocarditis.

A review of Patient #3's computerized clinical record revealed a standing physician order to "Offer Pneumovax vaccine if patient hadn't received any or if five or more years have passed

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| V 506 | Continued From page 7<br>since the last dose, with appropriate consent form signed."<br><br>Review of Patient #3's clinical record revealed a vaccination record. The vaccination record lacked evidence that Patient #3 received a pneumonia vaccine. An unsigned, undated entry indicated that he had never received any previous vaccine, but was interested in receiving one. An entry on the interdisciplinary progress notes revealed that, on 1/21/09, information was given to the patient regarding Pneumovax vaccine.<br><br>The Clinic Registered Nurse confirmed that the form was part of the admitting paperwork and completed on admission. At approximately 9:00 AM on 2/18/09, the Clinic Registered Nurse revealed that she was waiting for both the physician's order to administer the vaccine and the receipt of the vaccine. She indicated that she was not aware that the physician's order was on the admitting orders or that the vaccine had been present in the clinic for more than three weeks. She acknowledged she had no plan to administer the vaccine, but would do so on 2/20/09, although Patient #3 was present in the clinic. | V 506 | | |
| V 510 | 494.80(a)(7) ASSESSMENT CRITERIA<br><br>[The patient's comprehensive assessment must include, but is not limited to, the following:]<br>(7) Evaluation of psychosocial needs by a social worker.<br><br>This STANDARD is not met as evidenced by:<br>Based on clinical record review and interview, the | V 510 | | |

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| V 510 | Continued From page 8<br>facility failed to have evidence of a comprehensive psychosocial assessment for 1 of 4 patients. (#3)<br><br>Findings include:<br><br>Patient #3 transferred to the clinic on 1/14/09 from another clinic. Review of his current clinical record revealed a copy of an annual social history and assessment evaluation dated 12/7/07. No other social assessments were found.<br><br>Patient #3 had received dialysis for the past four years. He was on home hemodialysis treatments until he developed endocarditis and required an acute care hospitalization. He now received in-house dialysis treatments.<br><br>An interview with the social worker on 2/18/09, revealed that she was the social worker at the patient's prior and current clinics. The social worker indicated that she knew a lot about Patient #3's needs, but did not document them either as a summary from the other clinic record or updated his current records. | V 510 | | |
| V 552 | 494.90(a)(6) DEVELOPMENT OF PATIENT PLAN OF CARE<br><br>The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis. | V 552 | | |

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This STANDARD is not met as evidenced by:
Based on interview and clinical record review, the facility failed to provide evidence of appropriate and timely social service interventions to accommodate the psychosocial needs for 3 of 4 patients. (#2, #3, #1)

Findings include:

Patient #2 was a 70 year old who had been on dialysis since 2003. An interview with Patient #2 at 8:00 AM on 2/18/09, revealed that she had elderly family members who lived with her and assisted with her activities of daily living. This assistance included her 85 year old uncle who drove her back and forth to the clinic for dialysis. Prior to her transfer to the current clinic, Patient #2 was scheduled for dialysis on a second shift at the previous clinic with a start time of approximately 10:00 AM. Patient #2 transferred to the current clinic because it was closer to home and was scheduled to start dialysis at 6:00 AM. Patient #2 had requested a later start time because it was difficult for her to get up early. During the interview she confirmed that she could have a later start time once the clinic was fully operational. Patient #2 revealed during the interview that her uncle (driver) had trouble driving at night.

An interview with the clinic Charge Nurse and the social worker on 2/18/09, revealed that Patient #2 had requested a later start time because it was hard for her to come early. During the interview with the Charge Nurse, it was revealed that both she and the patient care technician were scheduled to work Monday, Wednesday and

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Friday at the clinic; only four patients were coming for treatment at the present time. The Charge Nurse confirmed that the clinic had 12 chairs and that clinic staff were scheduled for 10 hour shifts. The Charge nurse could not provide any reasons why Patient #2's treatment could not start later in the morning.

The interview with both the Charge Nurse and the social worker revealed that neither were aware of or had investigated the driving ability of the uncle. The social worker confirmed she had known Patient #2 at the other clinic, but acknowledged the social worker did not document any family psychosocial data into the current care plan.

Review of the clinical record revealed no specific care plans addressing a reasonable time frame to work with getting Patient #2 to a second shift or any other interventions to assist with a later start time.

Patient #3 had been on home hemodialysis, but developed endocarditis and now required in-house dialysis. He had been on dialysis for four years and transferred to the current clinic on 1/14/09.

Review of the clinic record revealed Patient #3 had requested assistance with vocational training. A note was written by the social worker on 1/23/09. The social worker documented that Patient #3 voiced interest in vocational rehabilitation for employment that would be more physically appropriate for his health needs. The social worker documented that she "provided contact information for VR (vocational rehab) counselor." There was no evidence that the social worker initiated contact or who Patient #3

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was referred to.

An interview with the social worker on 2/18/09, confirmed the social worker did provide Patient #3 with a contact name and number; Patient #3 was responsible for initiating the contact. She stated that she did it so that Patient #3 "could maintain his independence with his life needs." The social worker confirmed she did not document who this contact was or had care planned a time frame and goal for Patient #3 to accomplish the task. She also indicated that the information had been damaged (the paper went through the laundry) and that Patient #3 was not sure he could retrieve the information. The social worker indicated she had known Patient #3 for a period of time and did not document any of the information she should have regarding his psychosocial needs.

Patient #1 had originally dialyzed at a sister clinic for 2 years. She transferred to the current clinic on 1/28/09 and received dialysis three times a week for three hours and fifteen minutes each treatment. Her primary diagnosis was glomerulonephritis.

In a personal interview with the patient at approximately 8:00 AM on 2/18/09, she disclosed that she needed a secondary insurance in order to to be assured of a place on a transplant list. She further indicated that she was having a difficult finding any additional coverage. She mentioned several times how difficult things were since going on dialysis: not being able to work, the change in her health, and the reduction in income. Patient #1 had indicated that having money for her prescriptions was a problem.

Review of the record revealed that Patient #1 had

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problems with depression. The patient's record indicated that the social worker had given Patient #1 the information for an Advance Directive on 11/17/08, while she was still at the old facility and that the patient would return the paperwork when it was completed.

Review of her record revealed references in the progress notes dated 12/03/08 and 1/20/09, by the social worker of the need for a secondary insurance in order to secure a place on a transplant list. The social worker commented that she would assist. No evidence of a care plan addressing the need was found or indications as to how the social worker was assisting Patient #1 or what her time frames were to address the problems. No progress notes or indications as to how the search for a secondary insurance was proceeding were found.

The social worker acknowledged in her documentation that Patient #1 was depressed, but was refusing medications. The social worker wrote that she would offer the patient some stress reducers. There was no evidence of a care plan addressing the problem of depression. The reason why the patient was refusing medications was not addressed and no indications as to what the stress reducing methods were and if they had been effective was noted.

Documentation by the social worker indicated that Patient #1 was given the paperwork for the Advance Directive on 11/17/08. In a note dated 2/16/09, the social worker indicated that the paperwork had not yet been completed. There was no evidence that a care plan had been developed pertaining to the completion and returning of the Advance Directive paperwork or

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 292535 | A. BUILDING _____ B. WING _____ | 02/18/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIALYSIS CLINIC INC | 1281 KIMMERLING #A-1 GARDNERVILLE, NV 89460 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| V 552 | Continued From page 13<br>documentation indicating if there was a problem for the patient in developing an Advance Directive.<br><br>In the Universal Short Term Care Plan dated 1/16/09, the section under Biopsychosocial Functioning contained the same goals listed for the other patients in the facility: Rehabilitation resources utilized; Appropriate coping mechanisms discussed; Dialysis schedule maintained; Patient satisfied with care; and Other.<br><br>There was no evidence of individualized goals or problems with specific time frames for Patient #1 in the Biopsychosocial Functioning area of any type.<br><br>In a telephone interview with the social worker on 2/18/09, she indicated that she needed to do more in the way of care planning. | V 552 | | |
| V 727 | 494.170(a) PROTECTION OF THE PATIENT'S RECORD<br><br>The dialysis facility must-<br>(1)Safeguard patient records against loss, destruction, or unauthorized use; and<br>(2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following:<br>(i) The transfer of the patient to another facility.<br>(ii) Certain exceptions provided for in the law.<br>(iii) Provisions allowed under third party payment contracts.<br>(iv) Approval by the patient.<br>(v) Inspection by authorized agents of the Secretary, as required for the administration of the dialysis program. | V 727 | | |

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| V 727 | Continued From page 14<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure that the patients' medical information was safeguarded from unauthorized use or kept confidential for 2 of 2 observations.<br><br>Findings include:<br><br>The initial entrance occurred at approximately 8:30 AM on 2/17/09. The only staff member present was the Bio-med technician who was conducting a safety inspection. The office manager had left the office to go to another clinic to perform clerical errands. The Bio-med technician confirmed he probably would have left before the office manager's return if the surveyors had not arrived. The Bio-med technician confirmed he did not know when the office manager's estimated return was. He confirmed he would secure the building, but not the individual offices when he left.<br><br>An initial tour of the facility revealed that the clinical records of the four active patients and one discharged patient were located in a closet next to the fax/copy machine. This closet contained office supplies, local phone books and other clerical supplies.<br><br>The office manager was interviewed at approximately 10:00 AM on 2/17/09. She confirmed she had left the closet unlocked when she left the building in case the Bio-med technician needed the phone book or any other office supplies located in the closet. She was not aware that the Bio-med technician would not secure the closet when he left. She also confirmed that the clinic was open on Monday, | V 727 | | |

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|---|---|---|---|---|
| V 727 | Continued From page 15<br>Wednesday and Friday; clinic cleaning was scheduled on days the clinic was closed.<br><br>During a patient observation on 2/18/09, the office manager used the intercom to inform the registered nurse that a lab result had been received. The office manager said the patient's full name and what lab test had been performed. The intercom message could be heard in the general patient care area. There was still one patient receiving treatment in the unit.<br><br>Cross reference V 455 - Patients' Rights | V 727 | | |